

April 25, 2003

Re: MDR #: M2-03-0713-01  
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_\_ for an independent review. \_\_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic Surgery.

Clinical History:

This 53-year-old male was injured on his job on \_\_\_\_\_. He was treated for the next twenty months with medication (oral and topical), chiropractic manipulations, joint mobilization, myofascial release, and multiple other physical therapy modalities, and injections. He had several consultations and Functional Capacity Evaluations.

Disputed Services:

Lumbar radio frequency rhizotomy and sacroiliac joint radio frequency.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that above-named treatments are not medically necessary in this case.

Rationale for Decision:

An extensive pain management program, right and left sacroiliac joint injections, and lumbar facet joint injections with local anesthetic and steroid, and three epidural steroid injections have not resolved the patient's complaints of back and lower extremity pain and paresthesias. The MRI of 09/13/01 revealed an L4-5 disc protrusion, which is an objective diagnosis compatible with his subjective findings. Non-surgical pain management techniques are unlikely to relieve this patient's problem.

I am the Secretary and General Counsel of \_\_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known

conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by \_\_\_\_ is deemed to be a Commission decision and order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity** (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on April 25, 2003

Sincerely,